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ABSTRACT

This seventh annual report card is produced to heighten awareness of the health of the children of North Carolina by summarizing important child health indicators. The report is intended to assist health administrators, legislators, and family advocates in their efforts to improve the health and safety of children statewide. Data are presented for the most current year available and a comparative year (usually 1995) as a benchmark. The following indicators are used: (1) insurance coverage; (2) infant mortality; (3) low birth-weight infants; (4) immunization rates; (5) communicable diseases; (6) environmental health; (7) dental health; (8) early intervention; (9) child abuse and neglect; (10) deaths due to injury; (11) alcohol, tobacco, and substance abuse; (12) physical fitness; (13) obesity; and (14) teen pregnancy. Grades are assigned for each indicator based either on the percentage change in an indicator's current data in relation to the same indicator in a prior year, or on a general consensus among the sponsoring organizations. The report notes that for several indicators--including infant and child death rates, uninsured rates, the immunization rate--the data are the best ever reported. However, for several other indicators--including child abuse and neglect, child abuse homicides, asthma, obesity in low-income children, and the use of alcohol, tobacco, and illegal substances--the data remain extremely worrisome. The report concludes with data notes and definitions. (HTH)

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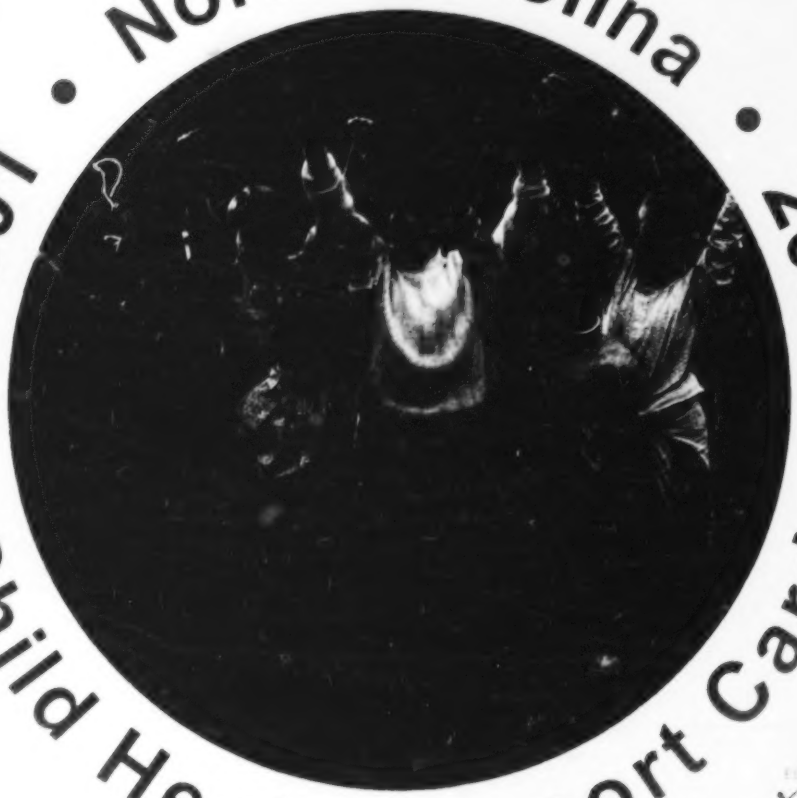

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The purpose of the North Carolina Child Health Report Card is to heighten awareness of the health of our children by summarizing in one brief document data on important child health indicators. This seventh annual Report Card is produced to assist health administrators, legislators, and family advocates in their efforts to improve the health and safety of children statewide.

Data are presented for the most current year available and a comparative year (usually 1995) as a benchmark. Unless otherwise noted, data are presented for calendar years. The specific indicators were chosen not only because they are important, but also because there are data available. Hopefully, expanded data systems will begin to produce accurate data that would allow the "picture" of child health and safety to expand as well.

Y2K, which began with both celebration and anxiety, ended with the same mixed feelings about the health of our children. There is plenty to celebrate. For several indicators—including infant and child death rates, uninsured rates, the immunization rate—the data are the best ever reported. There are also plenty of reasons for anxiety. For several indicators—including child abuse and neglect; child abuse homicides; asthma; obesity in low-income children; and the use of alcohol, tobacco, and illegal substances—the data remain extremely worrisome. Racial disparities remain disturbingly wide.

As noted in prior Report Cards, North Carolina's child health outcomes are not a matter of happenstance. Invariably, our results—good, bad, or indifferent—closely mirror investments made by the General Assembly and the hard work and perseverance of coalitions that include state and local agencies, providers, and child/family advocates. Regrettably, the current state budget crisis is placing much of this progress in jeopardy, with some critical health services being reduced and most remaining underfunded. While the frequently-heard goal of being "First in America" in the formal education of our children is laudable, there is no way to achieve that goal if our children are nowhere near first in measures of health and safety. Attention to the relationship between student health/well-being and student success in school is a challenge for all North Carolinians.

Grades

Grades are based on either the percentage change in an indicator's current data in relation to the same indicator in a benchmark year, or on a general consensus among the sponsoring organizations. Generally, the following guidelines are used: A = 25% or greater improvement or current status remains "very good"; B = 11-25% improvement or current status remains "satisfactory"; C = no significant change (between 11% improvement and 11% decline) or current status remains "mediocre"; D = 11-25% decline or current status remains "unsatisfactory"; F = 25% or greater decline or current status remains "very poor". In general, pluses (+) and minuses (-) indicate where a grade falls at the threshold between two letter grades.

Tom Vitaglione (NCCAI) and Kristie Weisner (NCIOM) led the development of this publication, with valuable contributions from many staff members of the North Carolina Department of Health and Human Services.

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Health Indicator	Current Year	Benchmark Year	Δ	Grade
Insurance coverage[1]	**2000**	**1997**		
Health Choice enrollment	74,145	0	N/A	A
Medicaid enrollment	506,716	491,286	+ 3.1%	C
% of all children (0-18) in target group uninsured	13.3	15.7	-15.3%	B
% of all children (0-18) uninsured	10.4	11.8	-11.9%	B
Medicaid Preventive Care[2]	**2000**	**1995**		
% of Medicaid-enrolled children (0-18) receiving preventive care	66.8	49.9	+33.9%	A-
Infant Mortality[3]	**2000**	**1995**		
# of infant deaths per 1000 live births:				
All	8.6	9.2	-6.5%	B-
White	6.3	6.8	-7.4%	B
Non-white	14.4	15.0	-4.0%	D
Low Birth-Weight Infants[4]	**2000**	**1995**		
% of infants born weighing 5.5 lbs or less:				
All	8.8	8.7	+1.1%	D
White	7.1	6.8	+4.4%	D
Non-white	13.0	13.2	-1.5%	D
Immunization Rates[5]	**2000**	**1995**		
% of children with appropriate immunizations:				
At age 2	88	84	+4.8%	A
At school entry	98	98	0%	A
Communicable Diseases[6]	**2000**	**1995**		
# of newly reported cases (age 0-19):				
Congenital Syphilis	17	33	-48.5%	B
AIDS	7	13	-46.2%	A
Tuberculosis	11	9	+22.2%	C
Vaccine-Preventable Communicable Diseases[7]	**2000**	**1995**		
# of cases (age 0-18):				
Measles	0	0	0%	A
Mumps	6	28	-78.6%	A
Rubella	24	0	N/A	D
Diptheria	0	0	0%	A
Pertussis	89	115	-22.6%	B
Tetanus	0	0	0%	A
Polio	0	0	0%	A

Health Indicator	Current Year	Benchmark Year	Δ	Grade
Environmental Health[8]	**2000**	**1995**		
Lead: % of children (age 12-36 months)				
Screened for elevated blood levels	33.7	21.9	+53.9%	C
Found to have elevated blood lead levels	2.4	7.0	-65.7%	A
Asthma: % of children (grade 7-8) who have:	**2000**	**1995**		
Reported asthma symptoms	28%	N/A	N/A	C
Diagnosed asthma	11%	N/A	N/A	C
Asthma: Hospital discharges per 100,000 children (age 0-14)	**2000**	**1995**		
All	201.3	287.9	-30.1%	C
White	87.5	149.1	-41.3%	B-
Non-white	225.6	412.2	-45.3%	C-
Dental Health[9]	**2000**	**1995**		
% of children:				
With one or more sealants (Grade 5)	34	25	+36.0%	B
With fluoridated water systems	89	87	+2.3%	A
% of Medicaid-eligible children:	**FY99-00**	**1998**		
Ages 1-5 who use dental services	16	12	+33.3%	D
Ages 6-14 who use dental services	31	27	+14.8%	D
Ages 15-20 who use dental services	18	19	-5.3%	D-
Early Intervention[10]	**2000**	**1995**		
# of children (age 0-3) enrolled in early intervention services to reduce effects of developmental delay, emotional disturbance, and/or chronic illness	8,342	7,593	+9.9%	B-
Child Abuse & Neglect[11]	**FY 99-00**	**FY 94-95**		
# of children:				
Receiving assessments for abuse & neglect	100,682	95,677	+5.2%	F
Substantiated as victims of abuse & neglect	31,828	29,749	+7.0%	F
	2000	**1995**		
Confirmed child deaths due to abuse	30	42	-28.6%	D
Child Fatality[12]	**2000**	**1995**		
# of deaths (age 0-18) per 100,000	80.6	89.5	-9.9%	B-

Health Indicator	Current Year	Benchmark Year	Δ	Grade
Deaths Due to Injury[13]	**2000**	**1995**		
# of deaths (age 0-18)				
Motor Vehicle-related	172	180	-4.4%	B-
Drowning	37	35	+5.7%	D
Fire/Burn	18	23	-21.7%	A-
Bicycle	6	10	-40.0%	A
Suicide	32	37	-13.5%	D
Homicide	54	48	+12.5%	F
Firearm	47	72	-34.7%	C-
Alcohol, Tobacco & Substance Abuse[14]	**1997**	**1993**		
% (Grades 9-12) who used the following in the past 30 days:				
Cigarettes	35.8	29.3	+22%	D
Smokeless Tobacco	7.4	11.1	-33%	C
Marijuana	24.9	14.8	+68%	F
Alcohol (beer)	42.7	43.7	-2.0%	D
Cocaine	3.0	2.2	+36%	F
Physical Fitness[14]	**1997**	**1993**		
% (Grades 9-12) who exercised at least 20 minutes a day, at least 3 days in the past week	55.3	59.1	-6.0	C
Obesity[15]	**2000**	**1995**		
% of low-income children who are overweight:				
Age 2-4	12.2	9.0	+36.6%	D-
Age 5-11	20.6	14.7	+40.1%	F
Age 12-18	26.0	22.7	+14.4%	D-
Teen Pregnancy[16]	**2000**	**1995**		
# of pregnancies per 1,000 girls (age 15-17):				
All	45.4	63.2	-28.2%	B-
White	36.3	48.6	-25.3%	B
Non-white	64.5	93.7	-31.2%	C

Notes:

1. Insurance Coverage. For many years, NC's Medicaid Program has been recognized as one of the better programs in the nation. NC Health Choice for Children, the new children's health insurance program implemented late in 1998, has now been acclaimed one of the best such programs in several national studies. A community-based outreach initiative led to exponential increases in Health Choice enrollment, while also increasing Medicaid enrollment. The best news is an analysis by the NC Institute of Medicine, which indicates that the percentage of uninsured children in the target group (those under 200% of the federal poverty guidelines) has decreased by more than 15% in less than three years. However, too many children remain uninsured, and much more progress is needed in this area. It should be noted that the Health Choice data mask the fact that enrollment increased beyond the program's resources, and enrollment has both declined and been frozen for much of 2001. The General Assembly has recently passed an appropriation to expand enrollment.

2. Medicaid Preventive Care. The percentage of Medicaid-enrolled children receiving preventive care on a continuing basis increased by almost 34% between 1995 and 2000. This significant increase can be attributed to the Carolina Access Program, which links enrolled children with primary care providers, and to the outreach efforts of the Health Check Initiative. The increase is even more remarkable because Medicaid enrollment increased significantly during this period due to expanded access provided by the General Assembly. Since more progress is needed in this area, it is critical that the Carolina Access Program and outreach efforts remain in place.

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3. Infant Mortality. The 2000 infant mortality rate of 8.6 is the lowest ever recorded in NC, representing a 6.5% reduction since 1995 and a remarkable 18% reduction in the past decade. This reflects great progress in reducing deaths from birth defects and sudden infant death syndrome. Both areas have received fiscal investments by the General Assembly and have been the focus of services and awareness campaigns generated by the Department of Health and Human Services and community agencies. Regrettably, these investments are in jeopardy due to the state's budget crisis. The disparity between white and non-white rates has been the focus of attention for some time, but the regrettable difference in outcomes has remained essentially unchanged.

4. Low Birth-Weight Infants. Low birth-weight is a serious component of infant mortality that has remained intractable over the years. Efforts to reduce this problem are now shifting to the preconception period. It has been noted that women with a history of positive health behaviors prior to pregnancy have better birth outcomes. School health curricula and general awareness campaigns can play a big role in this regard.

5. Immunization Rates. A federal report indicates that North Carolina's 88% immunization rate at age two was best in the nation in 2000.This true success story is directly attributable to a decision by the General Assembly to make vaccines available to children at low or no cost, and to a statewide initiative that enjoys the participation of primary care providers.

6. Communicable Diseases. While still disappointingly high, the number of newly-reported congenital syphilis cases has dropped dramatically in the past five years. Continuing progress is hoped for. There has also been a great drop in the number of newly-reported AIDS cases. Perhaps the best news is that the transmission of AIDS to the infant during birth is now a rare event. While the number of newly-reported tuberculosis cases remains relatively low, it is disappointing that this disease still affects our children.

7. Vaccine-Preventable Communicable Diseases. These diseases are no longer the childhood afflictions they used to be, due to the development of vaccines, the expanded availability of vaccines, and a statewide surveillance system guided by the NC Department of Health and Human Services. Measles, tetanus, polio, and diptheria have virtually been eliminated. Cases of mumps and pertussis have been markedly reduced. Outbreaks of rubella continue to occur, primarily in migrant populations. Surveillance and quick-response protocols have been instrumental in containing these outbreaks.

8. Environmental Health. The percent of children ages 12-36 months screened for blood lead levels has increased by more than 50% in the past five years, largely due to a statewide awareness initiative and the participation of private physicians and local health departments (and the WIC Programs in particular). However, only 33% of children were screened, a disappointingly low percentage given the adverse effects of elevated blood lead (defined as 10 micrograms per deciliter) on child development. Conversely, the percent of screened children who are found to have elevated blood lead levels has declined dramatically in the past five years, largely due to successful awareness campaigns and the continued reduction in exposure to products containing lead.

   The NC School Asthma Survey was conducted in 1999-2000 on most seventh- and eighth-graders and produced for the first time relatively accurate estimates of the prevalence of asthma. The prevalence of diagnosed asthma of 11%, with an additional 17% with asthma-like symptoms, confirms that asthma is the leading chronic illness among our school-age children. There were few differences in urban-rural and racial prevalence. However, the wide disparity in discharge rates by race appears to indicate that non-whites have less access to preventive and primary care services, necessitating their greater use of hospital care. The Asthma Alliance has been formed to aggressively address asthma from medical, educational, and environmental perspectives.

9. Dental Health. Data for preventive dental health, taken from the 1999-2000 Oral Health Survey conducted by the NC DHHS Oral Health Section, show steady gains. Awareness efforts regarding the effectiveness of sealants (and now fluoride varnish for young children) continue to be enhanced. Access to dental care for Medicaid-enrolled children is rising moderately, due to greater participation in Medicaid by dentists as a response to collaborative recruitment/outreach efforts by the Medicaid Program and the NC Dental Society. However, access rates are still very low, which is in part a reflection that dental reimbursement rates are too low. The General Assembly has recently approved a very modest increase in these rates.

10. Early Intervention. Program caseloads continue to increase, and NC's collaborative early intervention services system continues to receive national acclaim. Despite these impressive enrollment numbers, program administrators estimate that as little as 50% of the target population is being served. While efforts to expand and strengthen these services have been a priority of the Administration, the budget crisis has led the General Assembly to reduce appropriations in this area.

11. Child Abuse and Neglect. Though the number of children receiving assessments and the number of children substantiated as victims of abuse and neglect have moderated in the past few years, these numbers are alarmingly high. Were it a communicable disease, child abuse and neglect would be declared an epidemic in NC. Tragically, the 30 confirmed deaths due to abuse represent almost 60% of child homicides, further confirming that home can be a dangerous place for far too many of our children.

12. Child Fatality. The rate of child deaths in 2000 is the lowest ever reported, representing a 9.9% decline since 1995 and a 23% decline in the past decade. Declines occurred in all age categories. The NC Child Fatality Task Force as well as state and local review teams continue to explore ways to prevent child deaths.

13. Deaths Due to Injury. This is the primary cause of death in children older than one year of age. Even though the number of deaths has grown in some categories, the death rates for all categories have declined because the total number of children in the population has increased significantly in the past five years. Progress in motor vehicle-related deaths is attributed to the new graduated drivers' license requirements as well as increased enforcement of seat belt laws. Deaths due to drowning have been an intractable problem; a recent study indicates that most children who drowned were unsupervised by adults at the time. Vigilance is called for. Cases of homicide and suicide are a continuing tragedy.

14. Alcohol, Tobacco, Substance Abuse, and Physical Fitness. These data are derived from the biennial Youth Risk Behavior Survey conducted by the Department of Public Instruction in cooperation with the Centers for Disease Control and Prevention. Regrettably, this survey, the best source of comparative data over time, was not conducted in 1999 in NC. The Comprehensive Child Health Plan published by the NC Institute of Medicine in 2000 includes a strong recommendation that NC participate in the 2001 survey, and this was done. Data should be available soon.

15. Obesity. This is conservatively defined as a body mass index equal to or greater than the 95th percentile using federal guidelines. Concern about overweight prevalence occurs when it exceeds 5%. The NC data for all age groups are well above that level of concern, and are getting worse. This does not bode well, for childhood obesity can lead to adult problems, such as high blood pressure, heart disease, etc. While the children represented in these data are those who receive services in local health departments or school health centers and may not be representative of the state as a whole, the data are sending an important signal that must be heeded.

16. Teen Pregnancies. The national decline in teen pregnancies is being experienced in NC as well. However, it is clear that more progress must be made in this area. Of particular concern is the wide disparity in the white and non-white rates. The non-white rate continues to be almost twice the white rate and thus remains an area of great concern.

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